buildings in which plague continues to manifest itself after the application of the above measures should be vacated and destroyed to prevent the spread of the disease. Badly infected areas may be depopulated and the people removed therefrom, placed in detention camps for observation until the period of incubation is passed.

It should not be forgotten that plague is frequently a ship-borne disease and follows the lines of travel. This requires an outgoing quarantine and the fumigation of all vessels touching at infected ports prior to departure.

Plague is a disease slow to gain epidemic proportions. Planted on a virgin soil, its subterranean mode of development requires time for it to reach its greatest intensity. Nine years passed before the great London epidemic reached its height, but once the disease strikes root, it is difficult to eradicate and its climax is a horror.

THE EVOLUTION OF THE DISEASE-ENTITY CALLED MANIO-DEPRESSIVE INSANITY, AND ITS MAIN FEATURES.*

By A. W. HOISHOLT, M. D., Stockton.

(Concluded from page 292)

When in a case several attacks of maniacal excitement and depression have taken place, it is not difficult to diagnose manio-depressive insanity, although changes in the mental condition from elatedness to despondency or stupor are met with in general paralysis and katatonia; but when the history does not give information of previous characteristic changes in affects, and one is dealing with the manifestations of the first attack, it is often very difficult to come to a conclusion. If the patient in question is beyond the middle age, Kraepelin lays stress upon a differentiation between manio-depressive insanity and true melancholia or melancholia of senilescence, which he considers a disease quite distinct as to its inner nature from the former. In this, many psychiatrists disagree with him. Thalbitzer places melancholia of senilescence—depressive forms of devolutional psychosis, as (7) Dr. Farrar terms them, within the boundary of manio-depressive insanity, and ascribes the features which are especially characteristic of it to the influence of age. The only cases excluded by Thalbitzer from melancholia of senilescence are those of depressive Wahnsinn, which he thinks belong in a class by themselves. The chief clinical difference between true melancholia and manio-depressive insanity is an absence of psychomotor inhibition in the former, but as Thalbitzer has shown, this is also absent in the mixed form of manio-depressive insanity, called by Kraepelin and Weygandt "the agitated depression," which is characterized by depression of the affects and psychomotor excitation. How can one then differentiate this from melancholia, especially as this has been admitted by Kraepelin to be likewise subject to relapses? The mildest forms of manio-depressive insanity, which as Kraepelin says, pass imperceptibly into certain morbid personal peculiarities, and which perhaps never fall into the hands of the alienist, are frequently considered cases of hysteria, neurasthenia or hypochondriasis. In the conditions of hysterical excitation, which these attacks sometimes resemble, we miss the flight of ideas, the elated character of the emotions and the pronounced divertibility. The excitement is more theatrical in character, shows more childishly affected manner of talk and action. There is an impulse to act, but no general craving for activity and the excitement is of shorter duration.

Many of the cases diagnosed by some writers as acute or periodical paranoia are simply maniacal or depressive states—manifestations of the manio-depressive insanity, the diagnosis of which may usually be established by proving the presence of elatedness, loquaciousness, craving for activity, mild flight of ideas, increased divertibility, or on the other hand, thought-inhibition, hopelssness, irresoluteness, etc., or a mixture of these symptoms, proving that the apparent paranoic delusions are of an entirely different nature.

Cases of manio-depressive insanity, especially the cases of maniacal stupor, may sometimes resemble katatonia (dementia præcox), but such patients are not negativistic; they take more notice of their surroundings, are more approachable, not so peculiarly stiff—do not show the reserved demeanor when asked to shake hands. When they speak they give evidence of impoverishment of thought, but do not show the stereotypy or the non-sensical incoherency of the katatonic, nor are the ideas of unpardonable sin mixed with persecutory ideas as in katatonia or dementia præcox. Kraepelin mentions that maniacal as well as depressed cases are occasionally thought to be feeble-minded. He mentions a patient who for months would laugh to herself in a silly manner and at the most now and then give her neighbor a dig. Kraepelin had considered her feebleminded, but she recovered and after her recovery proved to be unusually bright, and well educated.

In conclusion it may be said that manio-depressive insanity is essentially a psychosis of the affects, its fundamental characteristic being that its affect-symptoms are only quantitatively differentiated from the physiological state of the feelings and emotions. As (8) Thalbitzer says "the psychosis discloses its origin as the pathological exaggeration of a physiological affect by showing a certain proportionateness between the depth of the depression and the grotesqueness of the despondent fallacious ideas. Whenever the depression becomes diminished the despondent ideas will likewise assume less monstrous dimensions."

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Discussion.

Dr. P. K. Brown, San Francisco: It is surprising the number of cases that come into the hands of the general practitioner, cases of insanity in individuals who have never before been insane, and from families where there is no reason to suspect this trouble. In this condition one has to deal with people whose extraordinary ignorance of the usual conditions is usually equaled by that of the physician. Early in my practice it became evident that the most valuable help I could have in dealing with the constant cases was a knowedge of the classification of these cases and an idea of the prognosis, because of the influence it always has in enabling one to advise what had best be done. I arranged with great interest a number of cases in this manio-depressive class of insanity. I get cases where I see that their symptoms months before would have been diagnosed as melancholia or neurasthenia. I recall a case of a personal friend who had the habit of wandering about the streets at night because of sleeplessness. The condition of muscular instability and first manifestations of acute mania came during one of these night wanderings when he saw a man talking loudy to a woman, and the result of his wild interference landed him in an institution. I was impressed with the fact that there was an unusual religious period of two or three months, as far back as six months. That there was a period of great mental activity, when he did an enormous amount of writing on subjects in which he was not ordinarily interested. I have had cases in the last two weeks, cases of manio-depressive insanity. After watching the patient one can sit down with the family and trace out incidents that should have been recognized by the family physician. I wish to emphasize what Dr. Hoisholt has said about the preliminary period of depression and the period in which there is very often marked evidence of increased religious feeling. This is the characteristic in a number of cases I have seen, and it is so distinct that mania occurs almost like the chill in malaria after a period of fever.

Dr. Gardner, San Francisco: I have been very much interested in this paper. If Kraepelin himself in the diagnosis of this insanity cannot place about 50% per cent of his cases, then I think the general practitioner may be excused for some of the mistakes mentioned. There is an excuse for the mistakes to a general extent, in that the general practitioner does not frequently come in contact with cases of this kind, and then only for a short period. The form of insanity the Doctor has called attention to is a new classification and a good one, in that many times we come in contact with cases where the maniacal condition makes us doubt whether to classify it as melancholia.

Dr. Hoisholt, Stockton: In studying these diseases one is dealing with an organ that does not secrete or excrete any substance that will enable one to learn something more definite with regard to its healthfulness. Kraepelin has tried to ferret out the nature of the disease that he studied and the only way to do that is to learn in the history of the case and the actions of the patient the way in which it is violating laws. I wish to lay stress upon this in connection with the study of insanity, that one must not stop with that but go into the study of the manifestations in the way that they deviate from the normal. The man in the asylum does not see these cases in the early stages. The only way to make progress in the knowledge of these cases is to pursue careful study of them before they arrive in the asylum. Opportunity of that kind can be afforded if the colleges had a clinic where the patients could come and the early stage could be outlined before leaving that institution. With regard to the frequency of the disease, I think that perhaps more than 15% will be reported later on. There is only one disease which is more frequent than that, and that is alcoholism.

SYPHILIS—EXTRA-GENITAL CHANCRES.*

By RALPH WILLIAMS, M. D., Los Angeles.

The subject of the extra genital mode of infection is of great interest to us and to society in general.

First: Because it is possible for any one thus to acquire a dangerous and mutilating disease in so many different ways, and to have their whole life made miserable, for no matter in what manner contracted, the disease by the laity is regarded as directly venereal or as hereditary, and carries with it a certain disgrace.

Second: As a value to society, for the reason that if there had been more cases of extra-genital infection, society, which at present even tabooes the name, would have looked upon the disease in its proper light, not as a punishment of vice, and of necessity as an indication of loose morality; but as a constitutional disease with the possibility of it being acquired by both a mediate and immediate manner of infection; possessing to its victims a danger, reaching into the lapse of years, and capable of being transmitted to their progeny. A knowledge of syphilis (old as man—protean as the devil) possessed by society would teach it to be more careful, more cleanly in the use of various articles, and realizing the dangers of this disease and having been taught the many avenues of infection, the people would have better understood and more generally aided in the subjugation of it and other diseases through the propagation of the many great sanitary reforms of recent years, or those which are to follow as prophylactic medical science mounts ever to its ideal. Society in general can hardly be blamed for its ignorance when we consider the fact that so many extra-genital chancres are never even suspected by the general medical man until the roseola or the mucous patch spurs his memory to the fact that even old friends may sometimes change their residence.

Case 1, September, 1900.—A miner, 40 years old, came to Los Angeles to have some dental work done. It became necessary to pull a left lower wisdom tooth. The laceration filled and apparently healed, but about 16 days later became sore and slightly swollen. He was treated by the dentist for several days. About twenty-three days after the ex-

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